Federal Fiscal Year 2001
FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

Federal Fiscal Year 2001
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OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: ***ALASKA***
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)
Elmer Lindstrom, Deputy Commissioner, Alaska Department of Health and Social Services
for Jay Livey , Commissioner

SCHIP Program Name(s): ***DENALI KIDCARE***

SCHIP Program Type:
X Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
Combination of the above

Reporting Period: ***Federal Fiscal Year 2001 (10/1/2000-9/30/2001)***

Contact Person/Title: ***Bob Labbe, Director, Alaska Division of Medical Assistance or Barbara Hale, Child Health Specialist, State, Federal & Tribal Relations, DMA***

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Submission Date: ***December 28. 2001***

(Due to your CMS Regional Contact and Central Office Project Officer by January 1, 2002)
Please cc Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program changes and progress during Federal fiscal year 2001 (September 30, 2000 to October 1, 2001).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 2000 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 2000, please enter "NC" for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

A. Program eligibility ***N/C***

B. Enrollment process ***The Mat-Su Outreach Project piloted an electronic application from March 1 – September 30, 2001. Applications were submitted electronically to the Denali KidCare office and a signature page and documentation followed in the mail. Given that applications are processed in the Denali KidCare office within 48 hours when mailed, and the fact that there was an eight day average turnaround for e-applicants to submit signature and documentation, the pilot had few participants. The Denali KidCare office received e-applications from the Mat-Su Borough through the pilot test evaluation period which coincided with FFY 2001 year-end.***

C. Presumptive eligibility ***N/C***

D. Continuous eligibility ***N/C***

E. Outreach/marketing campaigns ***The focus for outreach shifted to training on the pre-printed renewal, and Tribal Public Service Announcements (PSAs) were produced in 12 Native languages.***

F. Eligibility determination process ***N/C***

G. Eligibility re-determination process ***In May 2001, we implemented the pre-printed renewal form to simplify the renewal form and renewal process for our program recipients and to increase operational system efficiencies.***

H. Benefit structure ***N/C***

I. Cost-sharing policies ***N/C***

J. Crowd-out policies ***N/C***

K. Delivery system ***N/C***

L. Coordination with other programs (especially private insurance and Medicaid) ***N/C***

M. Screen and enroll process ***N/C***

N. Application ***N/C***

O. Other ***N/C***

1.2 Please report how much progress has been made during FFY 2001 in reducing the number of uncovered low-income children.

A. Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2001. Describe the data source and method used to derive this information.

The number of uninsured, low-income children in Alaska was reduced by 4,679. This number represents the net increase of children who were uninsured that are now insured through the S-CHIP expansion. The total number of enrolled children under S-CHIP expansion outreach efforts in FFY00 averaged 16,821 per month. The total expansion for FFY01 produced an average monthly enrollment of 21,500 children.

These enrollment figures include those enrolled under Title XXI plus those enrolled under Title XIX as a result of the S-CHIP outreach effort.

Previous reports were based on unduplicated enrollment counts on an annual basis. The methodology used here better reflects the Division of Medical Assistance budgetary process which is based on the average cost per member per month using historical data trends and on DMA management assumptions. Data Source: (JUCE), Juneau Utilization Claims Eligibility which is a stand alone Oracle Database that receives downloaded (MMIS) Medicaid Management Information System data on a monthly basis.

B. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

Twenty-one thousand five hundred children have been enrolled in Medicaid as a result of S-CHIP outreach activities and enrollment simplification. Data Source: (JUCE), Juneau Utilization Claims Eligibility which is a stand alone Oracle Database that receives downloaded MMIS data on a monthly basis.

C. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

Other evidence of progress toward reducing the number of uninsured, low-income children in Alaska is shown in the 2000 Behavioral Risk Factor Surveillance Survey (copy attached).

Question two asks – What type of health care coverage pays for most of this child's medical care? The 1999 BRFSS showed that 11.2% of 974 responses said that they had Medicaid or Medical Assistance health coverage for their child. In the 2000 BRFSS, 17.2% of 966 respondents said that they had Medicaid or medical Assistance health coverage for their child.

Question four asks – During the past 12 months, was there any time that this child did not have any health insurance or coverage? The 1999 BRFSS showed that 9.4% of 974 respondents said that their child did not have health coverage in the past twelve months. The 2000 BRFSS showed that 7.5% of 901 respondents said that their child did not have health coverage in the past twelve months.

D. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

____ No, skip to 1.3

__*X*__ Yes, what is the new baseline? ***The baseline according to the 1998 – 2000 CPS data of uninsured children under 200% of FPL is 16,000.***

What are the data source(s) and methodology used to make this estimate?
The data source is the CPS 1998 – 2000.
What was the justification for adopting a different methodology?
Alaska did not adopt a different methodology.
What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)
Like most small states, Alaska relies on the CPS data because it is too expensive to collect our own data. However, Alaska and all small states have serious concerns about the reliability of the CPS March Supplement data even when three-year merged samples are used to make estimates.

At the request of then HCFA (CMS), the Census Bureau created three-year merged samples and published baseline estimates for all states. For the same years (1998, 1999, and 2000) that we used to generate our estimated baseline number above, the Census Bureau estimated that there were 16,000 uninsured Alaskan children under 19

years of age in families with incomes at or below 200 percent of the Federal Poverty Level. They also provided a standard error of 3,200 which means that the Census Bureau has 90 percent confidence that Alaska's baseline estimate is between 12,800 and 19,200 children. However, the data used for estimating the baseline of uninsured children for implementation of the Title XXI Medicaid expansion under-estimated both the number of children with existing Medicaid coverage and the number of children with coverage through the Indian Health Service.

The three year merged samples for 1998, 1999, and 2000 CPS estimates reflect the results of a health insurance verification question implemented in the March 2000 and 2001 CPS, and therefore are not directly comparable with the three-year average from earlier years. The new verification questions specifically address if anyone in the household including the person answering the question was at any time in the named year covered by a health plan. It was hoped that the new verification questions would increase the reliability and validity of the estimate.

Had your state not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

It is extremely difficult to answer this question and compare progress since the 2001 CPS Supplement data for health care coverage status will not be available until at least October, 2002, and even then, a three-year merged sample will reflect health care coverage status in 1999, 2000, and 2001. The data that we received in the fall of 2001, reflected a three-year merged sample from 1998, 1999, and 2000. The lag makes it next to impossible to make anything but an educated guess.

According to U.S. Census Bureau Report entitled Health Insurance Coverage: 2000, P60-215, issued September 2001, the percentage and number of all people without health insurance coverage nationwide declined between 1999 and 2000 while, in Alaska, during the same time period, the proportion of people without health insurance coverage increased. It is important to note that the aforementioned is a report of single year data. Given the rather slow rate of growth or somewhat flat economy in Alaska, the fact that our economy often times is countercyclical to the national economy, and increased costs, there is no reason to believe that the uninsurance rate will decline. Progress is being made as evidenced by our enrollment numbers, and we know the children enrolled are in need given they meet the Federal Poverty Level guideline standards.

1.3 Complete Table 1.3 to show what progress has been made during FFY 2001 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1:	List your State's strategic objectives for your SCHIP program, as specified in your State Plan.
Column 2:	List the performance goals for each strategic objective.
Column 3:	For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
I. Reduce the number of uninsured children in Alaska by providing health care coverage through the expanded Medicaid Children's Health Insurance Program (SCHIP).	*I.1 Market the Children's Health Insurance Program*	1. *Number of applications distributed through non-traditional sites.* **Baseline: 0 Target: 10,000 Actual: 180,000** 2. *Number of clients enrolled through mail-in applications.* **Baseline: 0 Target: 2,758 Actual: 21,500** 3. *Number of targeted outreach initiatives.* **Baseline: 0 Target: 3 Actual: 26** Data Sources: *Division of Public Assistance Denali KidCare office and Division of Public Health outreach staff.* **Methodology***: Compare performance to baseline and to targets.* Progress Summary: ***This performance goal was accomplished and exceeded as shown on last year's report. The actual numbers shown above were modified to reflect FFY 2001 actuals in this report.***

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
	I.2 De-link SCHIP eligibility determination from public assistance programs and simplify eligibility process.	***1. Create separate SCHIP eligibility determination unit.*** ***2. Create mail-in application process and shorten application.*** ***3. Implement policy for continuous eligibility for children and eliminate asset test.*** 4. ***Eliminate face-to-face interview.*** Data Sources: Methodology: Progress Summary: ***All four of the performance measures were completed and implemented. This goal is accomplished***
	I.3 Enroll targeted low-income children in the Children's Health Insurance Program (SCHIP).	*Percent of targeted low-income children enrolled in SCHIP.* **Baseline: 0 Target: 4,900 Actual: 21,500** Data Sources: *quarterly reports to HCFA (data from MMIS)* Methodology: *unduplicated number of enrollees* Progress Summary: ***Total unduplicated number of children enrolled in SCHIP between 10/1/99 and 9/30/00 was 13,143. This goal was accomplished and exceeded in FFY 2000 as reported last year. The FFY 2001 actual is shown above.***

OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
N/A		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
II. Increase access to preventive care for SCHIP enrolled children	*II.1 Deliver EPSDT services to children enrolled in SCHIP at the same rate as children enrolled in regular Medicaid.*	*Percent of SCHIP and regular Medicaid children ages 6-18 eligible for screening who receive recommended EPSDT screenings.* Data Sources: *MMIS claims system and EPSDT subsystem* Methodology: ***CMS (HCFA) 416 report methodology was applied to the subgroup of Medicaid recipients who were eligible for S-CHIP in FFY99 and again in FFY00.*** Progress Summary: ***This method indicated that in FFY99 the SCHIP recipients accessed EPSDT services at rates much higher than the rates for Title XIX recipients. Closer analysis showed that the "average period of eligibility" calculation greatly affected the results for FFY99: because Alaska's SCHIP program was implemented in March 1999, the average period of eligibility for SCHIP recipients in FFY99 was much lower than that for all Medicaid recipients. This anomaly effectively inflated both the screening ratio and the participant ratio for SCHIP recipients for FFY99. In FFY00, when the average period of eligibility for SCHIP recipients was nearly the same as that for all Medicaid recipients, the HCFA 416 methodology showed that SCHIP recipients' rate of utilization of EPSDT screening services was slightly lower than the rate for other Medicaid recipients.*** ***SCHIP recipients ages 6-18 received preventive dental, dental treatment, and any dental services at rates lower than the rates for Title XIX Medicaid recipients in FFY 00.***

		In summary, while the overall rate of utilization of EPSDT screening services for SCHIP recipients closely mimicked the rate for Title XIX, dental utilization rates for the three categories mentioned above for SCHIP recipients were lower than the rates for Title XIX indicating a more emphasized focus on EPSDT dental outreach/promotion. FFY 01 416 data will be released to CMS 03/02 month end, and it will be interesting to see what the trend for the period corresponding to this report is given the new dental protocols highlighted in Section 3, J of this report.
N/A		Data Sources: Methodology: Progress Summary:
OTHER OBJECTIVES		
N/A		Data Sources: Methodology: Progress Summary:

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them.

All of the performance goals as outlined in the S-CHIP State Plan were met for the FFY 00 report. Under Section 1.3, Objectives Relating to Increasing Access to Care, in FFY 01, the State was just shy of meeting the goal, and given that the data supplied by the CMS 416 is FFY 00 data, it will be interesting to see what the trend actually is in 04/02 when the FFY 01 data is submitted. The FFFY 01 data will hopefully begin to reflect the measures taken in 2001 to address dental access as addressed in Section 3, J of this report.

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.

N/A

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available.

1.7 Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here.

- ***Alaska Behavioral Risk Factor Surveillance Survey 2000: Extract of Health Insurance Coverage for Children questions and analysis***
- ***Access to Health Care and Provider Participation In the Alaska Medicaid Program prepared by Vern Smith, Ph.D., Health Management Associates, April 2001***
- ***Denali KidCare Doer/Non-Doer Renewal Survey, June 2001***
- ***Consumer Assessment of Health Plans Survey (CAHPS), 2001 - this survey, or an executive summary, is not included as an attachment as was stated in last year's report, but will follow when the Division of Public Health resolves conflicts with weighting issues, and summarizes the results.***
- ***Pediatric Dental Clinics, Partnering with Native Regional Health Corporations***
- ***Denali KidCare Application Enrollment Survey – graphs of How You Heard of Denali KidCare and Where Obtained Denali KidCare Application***

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

A. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and re-determination, cost sharing and crowd-out.

N/A

B. How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2001 (10/1/00 - 9/30/01)?

__***N/A***__ Number of adults
__***N/A***__ Number of children

C. How do you monitor cost-effectiveness of family coverage?

N/A

2.2 Employer-sponsored insurance buy-in:

A. If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s).

N/A

B. How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2001?

__***N/A***__ Number of adults
__***N/A***__ Number of children

2.3 Crowd-out:

A. How do you define crowd-out in your SCHIP program?

If the applicant's income exceeds 150% FPL guidelines and they have voluntarily dropped insurance in the last 12 months, then they are not eligible, unless the Division of Medical Assistance determines they have good cause for dropping that insurance (i.e. severe economic hardship).

B. How do you monitor and measure whether crowd-out is occurring?

A denial report is run on a monthly basis to show the reasons for application denials.

Another process we use to monitor and measure the occurrence of crowd-out is the Medicaid Eligibility Quality Control pilot project where we had a Quality Assessment Team look at how accurate caseworkers had been at verifying existing health insurance coverage at the time of initial application. Additionally they were asked to look for indications of people dropping health insurance in order to qualify for Denali KidCare. The purpose of this pilot project was to assess how well our streamlined eligibility processes and policies were addressing concerns about crowd-out.

Of the 130 cases reviewed from September – December, 1999, only one was found to have dropped private health insurance before applying for Denali KidCare. Only nine percent of the sample actually had private health insurance available at the time of application. Of those that did have private health insurance available, 88% did not enroll because they could not afford it. This information as well as the results of other MEQC pilots were sent to Bob Reed, Manager, Medicaid Operations and Policy Cluster, Seattle, Washington, in a letter dated March 30, 2000.

C. What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

Data for FFY01 shows that less than one eighth of one percent (.094%) of denied applications were denied because of the applicant having "no good cause" for dropping health insurance within the prior twelve months. Fifteen percent of the denied applications were denied due to the applicant being over 150% of the FPL guidelines and having insurance. Both of these percentages declined over the previous year.

Of the total applications received in FFY 01 (14,608), less than 1/8 of one percent, or 3 applications, were denied because of the applicant having "no good cause" for dropping health insurance within the prior twelve months, and approximately 3.334%, or 487 applications, of the total applications received were denied due to the applicant being over 150% of the FPL guidelines and having insurance.

D. Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

The only crowd-out policy in place is the 12-month waiting period after voluntarily dropping health insurance.

2.4 Outreach:

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

Outreach via partnerships with a variety of organizations, agencies, providers and businesses have been instrumental to the success of the Denali KidCare program. An area where outreach efforts have been re-focused is to work with our partners in stressing the value of timely renewal to enrollees.

To promote the program we have continued to provide our message in a consistent and attractive format. All promotional materials are simple, colorful, respectful and non-governmental in appearance. Clearly the simplification of the application and renewal process was critical to making Denali KidCare more accessible. Leading our efforts to simplify the renewal process was the implementation (in May of 2001) of a pre-populated renewal form.

The Denali KidCare outreach staff have traveled literally tens of thousands of miles by aircraft (both large and small), boat, automobile, snow machine and all-terrain vehicle in order to network with community-based entities by delivering presentations, providing training and representing the program at Health Fairs and other community events.

Applications received are tracked and caseload data are updated on a weekly basis. A survey is included in the application packet to evaluate the success of outreach efforts and to provide information on client demographics.

Monthly reports from the survey provide information on how clients hear about the program and where they obtain the program applications, as well as on family size, community of residence, and income.

The survey illustrates that most new applicants hear about the program through friends, family and neighbors and receive their applications from a variety of sources. We receive completed surveys from 90% of the applicants. Copies of two graphs from the survey are attached.

B. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?

Our partnership with the Alaska Native Tribal Health Consortium has produced radio public service announcements (PSAs) in12 Alaska Native languages with English translations. To lend credibility to this "government" program, tribal elders recorded these spots. Through another partnership we produced a brochure that provides program information in Spanish, Korean, Tagalog, Samoan, Laotian and Russian.

Once again the extensive statewide travel accomplished by the state's outreach specialists provided communities with direct access to a representative of the program. Collaboration with community organizations and individuals has resulted in innovative approaches which have included a "Traveling Health Fair"

that visited several remote Prince William Sound villages via an oil-spill response ship and another partnership has assisted with a pediatric dental clinic which is traveling to most small communities in the southeast panhandle.

Quantitative measurement has been difficult - these efforts are oriented to building systems that provide community resources that are available long after the outreach specialist's visit. However the community response to these outreach efforts has been overwhelmingly positive.

C. Which methods best reached which populations? How have you measured effectiveness?

Direct contact through presentations to community groups and training people to act as local resources have proven to be effective strategies for reaching a wide variety of "special" populations. A booth at health fairs, community events and at professional conferences is also an important part of our efforts. School based efforts have played an important role.

As referenced in the FFY 2000 report, Outreach Specialists who spoke the language of various immigrant groups continued to provide outreach in FFY 2001 via mini-grantees; however, the evaluation of these mini-grantees is in process presently, and the results will not be available by the reporting deadline.

2.5 Retention:

A. What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

In May 2001, we began using a pre-populated or pre-printed renewal form to simplify the renewal process for both S-CHIP and Poverty Level Medicaid recipients. No longer are recipients required to fill out information that already exists in the case file. They are simply asked to make changes to the pre-printed information in the space provided If changes have occurred.

B. What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
X Renewal reminder notices to all families
___ Targeted mailing to selected populations, specify population
___ Information campaigns
X Simplification of re-enrollment process, please describe ***(SEE ABOVE)***
X Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe: ***We conducted a "Doer/Non-Doer" survey with customers who re-enrolled and those who had not re-enrolled during the summer. A copy of the analysis is attached.***

_X_ Other, please explain ***Outreach Specialists provide on-going training to community based organizations, providers, and others on pre-printed renewal simplification. Contact with these groups is essential to ensure that recipients understand the renewal process.***

C. Are the same measures being used in Medicaid as well? If not, please describe the differences.

The same measures are used for S-CHIP and Poverty Level Medicaid.

D. Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Anecdotally, we hear that recipients prefer the pre-printed renewal form and find it much easier to complete; however, we do not yet have enough data available to effectively analyze whether a greater number of recipients are renewing as a result of the new pre-printed form. In September, we have consistently seen a dip in numbers due to cases closed for failure to renew which we believe is due to seasonal employment, and the beliefs that families have that they are not eligible due to seasonal income.

E. What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

The "Doer/Non-Doer" survey mentioned last year under this section did not include questions to provide this information; consequently, at this time, we don't have data to answer the question.

2.6 Coordination between SCHIP and Medicaid:

A. Do you use common application and re-determination procedures (e.g., the same verification and interview requirements) for Medicaid and SCHIP? Please explain.

Yes, for S-CHIP, Poverty Level Medicaid and Pregnant Women we use common application and re-determination procedures.

B. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

A child is transferred from Family Medicaid or other categories of Medicaid if and when the eligibility for the other category is ending and Denali KidCare eligibility can be established. Some examples of when this might occur include when there are changes in household composition, age, income, or resources which cause the family to lose Family Medicaid eligibility. The case worker working the other category will

deny or close out involvement for the category they are working, send notice on their case and convert the case to Denali KidCare if the children are eligible for it. They will then send a notice informing the client of the change in Medicaid category. There is a paperless transfer of the case to Denali KidCare as no physical files are sent to the Denali KidCare Office. These cases that are converted from DPA offices to Denali KidCare are reviewed for correctness of actions, then assigned to the appropriate staff within the Denali KidCare Office.

C. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

Yes, the same delivery system, fee-for-service, is used in Medicaid and S-CHIP.

2.7 Cost Sharing:

A. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

N/A

B. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

N/A

2.8 Assessment and Monitoring of Quality of Care:

A. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.
Forthcoming as an addendum as stated in Section 1.7 of this report.

B. What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?
Forthcoming as an addendum as stated in Section 1.7 of this report.

C. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?
The Division of Public Health has a plan to administer the Consumer Assessment of Health Plan Survey (CAHPS) again in 2003. Accordingly, the executive summary of the data should be ready to submit with the FFY 03 S-CHIP Annual Report.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2001 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.

Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

A. Eligibility ***N/A***

B. Outreach and C. Enrollment

Alaska's outreach and enrollment continued to be extremely successful in FFY 2001. The 1998 funds that were reallocated to 12 states, Alaska being one of twelve, were exhausted within a short time period, and again Alaska was one of a few states who spent their 1999 allotment of Title XXI monies early, well in advance of the September 30, 2001 deadline.

Given Alaska's enrollment success, our focus is shifting to more emphasis on access to care issues as evidenced with our Express Application Pilot (expedited eligibility for children requiring specialized health care not available in their home community) through the Alaska Native Tribal Health Consortium and our work on dental issues described in J of this section. This is in alignment with the Robert Wood Johnson Foundation's focus on access to care issues in the second tier of the Covering Kids and Families grants. If the Alaska Native Tribal Health Consortium receives funding for the first tier of the Covering Kids and Families grant in 2002, then they will have the opportunity to apply for the second tier of CKF grants as referenced above.

D. Retention/disenrollment

In May, 2001, as mentioned previously in this report, we began distributing a "pre-populated" or the terminology used in our state, a pre-printed renewal form. Anecdotally, reports are that it has streamlined the renewal process.

E. Benefit structure ***N/A***

F. Cost-sharing ***N/A***

G. Delivery system ***N/A***

H. Coordination with other programs

Since Denali KidCare is a Medicaid Expansion and not a separate S-CHIP, we are reporting coordination with other state programs in Alaska rather than coordination with the Medicaid program as a separate S-CHIP would do. During FFY 2001, one of many successes in coordination with other programs that was new was the development of a tear-off information form featuring the Federal Income Guidelines pertinent to our state for Emergency Medical Service staff to provide to families in emergent situations to inform them about the Denali KidCare program and eligibility. This was a "peace of mind" accomplishment targeted at families who often times find themselves overwhelmed during a crisis, and established a door to EMS staff for Denali KidCare outreach.

I. Crowd-out ***N/A***

J. Other

As reported in this section during FFY 2000, access to dental services was a critical needs area identified by S-CHIP customers. To begin to address this issue, during FFY01, one of the Native Regional Health Corporations, Southeast Alaska Regional Health Corporation, piloted a contracted supplemental pediatric dental project delivering pediatric dental services to villages in Southeast Alaska, serving both the Native and non-Native children's populations for those who either were enrolled in Denali KidCare or other Medicaid program or had proof of applying for one of the programs. The overall objective was to improve access through supplemental contracted pediatric dental services in the villages so that children are able to receive services in their home communities rather than being transported to the regional hubs. The pilot program was highly successful with approximately 1,700 patient visits and the financial contribution from billable services above the breakeven point. The model was replicated and distributed to all Native Regional Health Corporation dental chiefs at the end-of-the-year (a copy of the Power Point Presentation is enclosed).

A "dental access" pilot, not mentioned in last year's report, continued into this fiscal year in the Kenai/Soldotna area. It incorporated dental education, education on keeping appointments, and assistance to clients in making dental appointments as a means to involve low-participating dentists in seeing new Medicaid clients in their practices.

Additionally during FFY 2001, a full-time dental director was hired to work on oral health surveillance and access issues and the Division of Medical Assistance streamlined claims processing for dentists as well as addressed dentist's legal concerns with the Medicaid program to name several of the steps taken to increase access to dental care.

SECTION 4: PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 **Please complete Table 4.1 to provide your costs for FFY 2001, your current fiscal year budget, and FFY 2003-projected budget. Please describe in narrative any details of your planned use of funds.**

N*ote: Federal Fiscal Year 2001 starts 10/1/00 and ends 9/30/01).*

	Federal Fiscal Year 2001 costs	Federal Fiscal Year 2002	Federal Fiscal Year 2003
Benefit Costs			
Insurance payments			
Managed care			
Per member/per month rate X # of eligibles			
Fee for Service	**$33,678,566***	**$36,300,000****	**$39,500,000****
Total Benefit Costs	**33,678,566**	**36,300,000**	**39,500,000**
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs			
Administration Costs			
Personnel	**$25,685**	**$25,700**	**$27,000**
General administration	**12,351**	**12,500**	**13,500**
Contractors/Brokers(e.g., enrollment contractors) (DPA RSA)	**1,148,391**	**1,150,000**	**1,200,000**
Claims Processing			
Outreach/marketing costs	**1,239,500**	**1,300,000**	**1,300,000**
Other	**150,000**	**150,000**	**150,000**
Total Administration Costs	**2,575,927**	**2,638,200**	**2,690,500**
10% Administrative Cost Ceiling	**3,367,857**	**3,630,000**	**3,950,000**
	(72.09%)	**(70.17%)**	**(67.76%)*****
Federal Share (multiplied by enhanced FMAP rate)	**26,135,864**	**27,322,935**	**28,588,283**
State Share	**10,118,629**	**11,615,265**	**13,602,217**
TOTAL PROGRAM COSTS	**$36,254,493**	**$38,938,200**	**$42,190,500**

***Data Source: DMA Title XXI Transfer Data (JUCE)**
****FF02 – FF03 – Projections based on historical expenditure data and budget assumptions**
*****Preliminary estimated enhanced rate – This calculation assumes no congressional adjustment**

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2001.

N/A

4.3 What were the non-Federal sources of funds spent on your SCHIP program during FFY 2001?

__X__ State appropriations
_____ County/local funds
_____ Employer contributions
__X__ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.

The Robert Wood Johnson Foundation grant "Covering Kids" will end during FFY 2002.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Program Name	***Denali KidCare***	
Provides presumptive eligibility for children	___X___ No _____Yes, for whom and how long?	_____No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___ Yes, for whom and how long? ***For S-CHIP, Poverty Level Medicaid, & Pregnant Women for three months prior to application with income verification.***	_____No _____Yes, for whom and how long?
Makes eligibility determination	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff ___X___ Other *(specify)* ***Division of Public Assistance***	_____State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months– ***We have six months of continuous eligibility, but currently do not have this information available.***	Specify months
Has joint application for Medicaid and SCHIP	_____No ___X___ Yes ***Includes Poverty Level Medicaid, Pregnant Women, and Expansion Children.***	_____No _____Yes
Has a mail-in application	_____No ___X___ Yes	_____No _____Yes
Can apply for program over phone	___X___ No _____Yes	_____No _____Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over internet	__X__ No ***An e-app was piloted under the Mat-Su pilot*** _____Yes ***(submitted as an e-mail attachment) during FFY 01. Signature page and verification followed via regular mail.***	_____No _____Yes
Requires face-to-face interview during initial application	__X__ No _____Yes	_____No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	_____No __X__ Yes, specify number of months – ***12*** What exemptions do you provide? ***We provide a good cause exemption.***	_____No _____Yes, specify number of months What exemptions do you provide?
Provides period of continuous coverage <u>regardless of income changes</u>	_____No __X__ Yes, specify number of months - ***6*** Explain circumstances when a child would lose eligibility during the time period – ***A child would lose eligibility if he were not a resident of the state or if he died.***	_____No _____Yes, specify number of months Explain circumstances when a child would lose eligibility during the time period
Imposes premiums or enrollment fees	__X__ No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	_____No ***Imposed only for 18 year old non-pregnant, non-*** __X__ Yes ***Natives.***	_____No _____Yes
Provides preprinted re-determination process	_____ No __X__ Yes, we send out form to family with their information precompleted and: __X__ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No _____ Yes, we send out form to family with their information and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the re-determination process differs from the initial application process.

For an initial application the client or clients will have no open involvement in any office and therefore must complete an application. If the client/clients have other open program involvement a verbal request for Medicaid/Denali KidCare services may be appropriate. A re-determination differs because it is completed either on an ongoing basis or on denials for initial applications where the household includes either optional or excludable household members. For ongoing cases, when a change is reported to the caseworker, the change may or may not affect the families' ongoing eligibility. The caseworker must determine if the reported change requires a case action. If so, the caseworker must then determine if additional information is needed to correctly apply the change to the case. A re-determination may also be appropriate when an initial application for Medicaid services leads to a determination that a household is not eligible for the category that they had applied for. In this situation, the eligibility worker must re-determine eligibility by excluding any optional or excludable members. A Medicaid re-determination may result in the loss of one category of Medicaid, or it may result in the loss of Medicaid for certain household members. A re-determination ensures that if a category of Medicaid is lost, all other possible categories are examined and that benefits are given to eligible household members for the appropriate category of Medicaid. If members of the household are optional or excludable members, it also ensures that all possible household combinations are examined for possible eligibility. Children under all Medicaid categories continue to receive six months of continuous eligibility regardless of the category of Medicaid they receive. For the Denali KidCare program the re-determination process is a bit different. When a report of change is received for a Denali KidCare case, it is noted in the file by use of the alert system, in the case notes or some other means. At the time of renewal the change would then be looked at to determine the impact on the household's continued eligibility.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2001, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher

133% of FPL for children under age 6 without insurance
100% of FPL for children through age 18 born ≥ 9/30/83 without insurance
71% of FPL for children through age 18 born < 9/30/83 without insurance
150% of FPL for children with insurance who would otherwise be S-CHIP eligible

Medicaid SCHIP Expansion

200% of FPL for children age 18 and under
____% of FPL for children aged _____
____% of FPL for children aged _____

Separate SCHIP Program

____% of FPL for children aged _____
____% of FPL for children aged _____
____% of FPL for children aged_____

6.2 As of September 30, 2001, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter "NA".*

Do rules differ for applicants and recipients (or between initial enrollment and re-determination)

____ Yes **X** No

If yes, please report rules for applicants (initial enrollment).

Table 6.2			
	Title XIX Child Poverty-related Groups	**Medicaid SCHIP Expansion**	**Separate SCHIP Program**
Earnings	**$90**	**$90**	$
Self-employment	***$Actuals***	***$Actuals***	$
Alimony payments Received	***$N/A***	***$N/A***	$
Paid	***$N/A***	***$N/A***	$
Child support payments Received	***$Actuals***	***$Actuals***	$
Paid (Actual deduction in FFY 02)	***$N/A***	***$N/A***	$
Child care expenses - Under age 2 Age 2 or >	**$200 $175**	**$200 $175**	$
Medical care expenses	***$N/A***	***$N/A***	$
Gifts	**$30**	**$30**	$
Other types of disregards/deductions (specify) Alaska Native Corporation Dividends (1st $2000 exempt)	**>$2000**	**>$2000**	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups

_***X***_No___Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program

__***X***_No____Yes, specify countable or allowable level of asset test_____

Separate SCHIP program

____No____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____

____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2001?
_X_ Yes ___ No

Yes, since November 1, 2001 (FFY 2002), we have changed a policy on child support payments made. Actual deductions are now subtracted from total income to arrive at total countable income.

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2002 (10/1/01 through 9/30/02)? Please comment on why the changes are planned.

A. Family coverage ***N/A***

B. Employer sponsored insurance buy-in ***N/A***

C. 1115 waiver ***N/A***

D. Eligibility including presumptive and continuous eligibility ***N/A***

E. Outreach ***The State will no longer be the lead agency for the Covering Kids, Robert Wood Johnson Foundation, grant. The Alaska Native Tribal Health Consortium has applied for the RWJ Covering Kids and Families grant. Outreach for the program will continue to be conducted by State staff in conjunction with the Alaska Native Tribal Health Consortium and their two pilot sites under the grant, the Alaska Primary Care Association and the South Central Foundation. The ANTHC was one of two pilots under the RWJ Covering Kids grant with the State of Alaska as the lead agency, and little will change with the exception that the lead will be transferred.***

F. Enrollment/re-determination process ***N/A***

G. Contracting ***N/A***

H. Other ***N/A***

2000 BRFSS State Added Child Health Care Coverage/Access

Introduction:
This document gives a brief overview of draft results from the state added children's health insurance questions on the 2000 Behavioral Risk Factor Survey (BRFSS). The data presented here are weighted. The sample for this analysis was people who reported having one or more children in their households between 0 and 17 years of age.

Questions for this Analysis:

1. I would like to ask questions about the child in your household who had the most recent birthday and is under 18 years old. What is this (Child's) age?
2. What type of health care coverage pays for most of this (Child's) medical care?
3. Other than (fill in from #2 above) does this (Child) have any other type of health care coverage?
4. During the past 12 months, was there any time that this (Child) did not have any health insurance or coverage?
5. About how long has it been since this child had health care coverage?
6. About how long has it been since this child visited a doctor for a routine checkup or physical exam?
7. Was there a time during the last 12 months when this child needed to see a doctor but could not because of the cost?

Miscellaneous Results:

- 2083 people answered the survey in 2000. This is the largest sample since BRFSS was initiated as an on-going yearly survey in 1991. Not quite half of the sample had households with children.
- While 966 households reported having a child less than 18 years old, the number of responses varies by question and this is noted in the question results section of the document.

Question Results:

1. I would like to ask questions about the child in your household who had the most recent birthday and is under 18 years old. What is this (Child's) age?
   - *(Number of Responses = 966) The average age of the child who had the most recent birthday was 9 years.*

2. What type of health care coverage pays for most of this (Child's) medical care?
(Number of Responses = 966)

Main Type of Health Care Coverage	Overall
Parent's or guardian's employer	53.3%
A plan that the parent or guardian buys on his own	5.6%
Medicaid or Medical Assistance	17.2%
The military, CHAMPUS, TriCare, VA, or CHAMP-VA	9.1%
The Indian Health Service	6.9%
A group plan through a parent's or guardian's previous employer or retirement plan	0.5%
Some other Source	1.9%
None	3.9%
Unknown/Refused	1.6%

3. Other than (fill in from #2 above) does this (Child) have any other type of health care coverage?
(Number of Responses = 901)

Secondary Type of Health Care Coverage	Overall
Parent's or guardian's employer	8.7%
A plan that the parent or guardian buys on his own	1.6%
Medicaid or Medical Assistance	3.6%
The military, CHAMPUS, TriCare, VA, or CHAMP-VA	1.0%
The Indian Health Service	6.3%
A group plan through a parent's or guardian's previous employer or retirement plan	0.1%
Some other Source	1.0%
None	75.0%
Unknown/Refused	2.7%

4. During the past 12 months, was there any time that this (Child) did not have any health insurance or coverage?
(Number of Responses = 901)

No Health Insurance/Coverage Past 12 Months	Overall
Yes	7.5%
No	91.3%
Don't Know/Not Sure	1.1%

5. About how long has it been since this child had health care coverage?
(Number of Responses = 48, Very small sample these numbers very unreliable)

How long since child last had health care coverage	Overall
Within the past 6 months	35.3%
Within the past year	11.0%
Within the past 2 years	4.0%
Within the past 5 years	9.2%
5 or more years ago	6.1%
Don't know/Not Sure	5.6%
Never	28.8%

6. About how long has it been since this child visited a doctor for a routine checkup or physical exam?
(Number of Responses = 966)

How long since last routine checkup/physical exam	Overall
Within the past 6 months	84.8%
Within the past year	6.0%
Within the past 2 years	2.5%
Within the past 5 years	0.6%
Don't know/Not Sure	5.8%
Never	0.2%
Refused	0.1%

7. Was there a time during the last 12 months when this child needed to see a doctor but could not because of the cost?
(Number of Responses = 966)

Needed to see Dr during past 12 months but could not afford	Overall
Yes	2.9%
No	96.4%
Don't Know/Not Sure	0.7%

Other Remarks:
Small numbers only 48 people reported that their children were without health care coverage, so it will be hard to conduct much further analysis on this group.

Where obtained Denali KidCare application